

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 10-19-01 through 11-5-01.
- b. The request was received on 3-6-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. Response to a Request for Dispute Resolution
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-28-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 7-1-02. The response from the insurance carrier was received in the Division on 7-15-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: No position statement:
2. Respondent: Letter dated 7-10-02:

"We admit that there may be a delay in processing of medical bills of the above referenced. It is our understanding that the bills in question are for DOS: 10/19/01 and 11/5/01."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 10-19-01 and extending through 11-05-01.

2. The Carrier's EOBs reflect a denial of "850-017 – NOT ACCORDING TO TREATMENT GUIDELINES \$0.00"; and "F – FEE GUIDELINE MAR REDUCTION".

However, for dates of service 10-22-01 through 11-5-01, the EOBS reflected all disputed amounts were recommended for reimbursement.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
10-19-01	97750-FC	\$300.00	\$-0-	850-017	\$100.00 per hr.	MFG; Medicine Ground Rules; (E) (2); TWCC Rule 134.401 (c) CPT Descriptor	<p>The carrier has denied the disputed service based on a "850-017 – NOT ACCORDING TO TREATMENT GUIDELINES \$0.00".</p> <p>The carrier has not expounded on the "850-017" denial by not listing the specific areas of the Treatment guideline that the Provider has failed to follow. TWCC Rule 133.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." The Carrier has not provided sufficient explanation of their denial of "T", as required by Rule 133.304 (c).</p> <p>Therefore, reimbursement is recommended in the amount of \$300.00.</p>

10-22-01	97545-WH	\$130.00 (2 hrs)	\$-0- for all dates of service	F for all dates of service	\$64.00 per hr.	MFG; Medicine Ground Rules (II) (F); CPT Descriptor	The carrier has denied the disputed services based on a denial of, "850-017 – NOT ACCORDING TO TREATMENT GUIDELINES \$0.00". EOBs for the dates of service in dispute reflect recommended payment for the MAR value. The Carrier has already recommended reimbursement based on a "F" reduction. Therefore, it is the determination of the Medical Review Division that reimbursement is recommended in the amount of \$4,480.00 if payment has not already been made. (MAR value for each hr. billed is \$64.00. \$64.00 x 70 hrs = \$4,480.00)
10-23-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
10-24-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
10-26-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
10-29-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
10-30-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
10-31-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
11-01-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
11-02-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
11-05-01	97546-WH	\$325.00 (5 hrs)					
	97545-WH	\$130.00 (2 hrs)					
Totals		\$4,850.00					

The above Findings and Decision are hereby issued this 27th day of September 2002.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$4,780.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 27th day of September 2002.

Carolyn Ollar
Medical Dispute Resolution Supervisor
Medical Review Division

CO/ll